Mike Rankin, LMFT

Licensed Marriage and Family Therapist
AAMFT Clinical Member
8151 New LaGrange Road Louisville, KY 40299
502-494-2929 rankinicloud@me.com

WELCOME!

I hope you find counseling helpful and useful. My pledge is to work so you feel understood and that you meet or exceed your goals and expectations.

Counseling is a conversation in which you and I talk about your life situation and see what changes you want to make to overcome obstacles. You may be in some pain, dealing with suffering and going through difficult times.

I listen to your concerns and together we find solutions to problems such as relationship stressors, depression, anxiety, work, grief, alcohol / drug abuse, and other difficulties. These experiences of life are often painful and counter-productive.

Together we can create new experiences for you, regain positive energies to recover your strengths and gifts, in order to meet the challenges of life, experience more rewards, and create meaning and purpose in life.

Counseling may be just what you want for a period of time – giving you long-term positive results. We can work together to make this a growing experience.

YOU AGREE TO THESE POLICIES ON YOUR REGISTRATION FORM.

FINANCIAL AGREEMENT

- Regular sessions are $90.00. Family /Longer sessions are $100. The intake is $100. If insurance is not used.
- **In hardship, fee payment may be negotiated.**
- Most other services are provided at the hourly rate of $120. A few other services may be billed at a higher rate. Returned checks incur a $40 fee in addition to bank fees. These fees are never covered by 3rd-party payers & must be paid for by you.
- All disability, court paperwork and telephone consultations are your personal responsibility and are billed at $140 per hour at $35 increments.
- Co-pays, etc., are estimates until an E*xplanation of Benefits* is received from the 3rd-party payer. Usually the 'specialist' amount on the insurance card must be paid.
- I do not have the capability of producing client statements. Your cancelled check or card record is your receipt. If you pay cash and need a receipt, ask for one at the time of payment only.

CANCELLATION, LATE, NO-SHOW

- *24-hour notice* is required for cancellation or up to $140 may be charged.
- You must give notice by leaving a message on my voice mail or speaking directly with me.
- You being late for your appointment cannot be allowed to interfere with clients coming after you. If you are late, your session may need to be shortened; you may also be charged a late fee.

3rd-PARTY PAYER RELEASE AND ASSIGNMENT

- You authorize the release of information necessary to process your 3rd-party payer claims, to document treatment, or to collect payment.

- You authorize payment directly to me. You agree this authorization covers all services rendered. You agree a copy of your authorization may be used in lieu of the original.
- You acknowledge that 3rd-pary payers place limits on the number of sessions for which they will pay.
- 3rd-party payers contract with me for discounts off my standard fees. You acknowledge being responsible for all remaining non-covered fees such as co-pays and deductibles and any other non-contracted services that I may provide.
- Non-covered fees must be paid before any service is provided.
- 3rd-party payers require you to provide *Coordination of Benefits* information to them. If you do not do so, you are responsible for the total cost of related services.

PAYMENT AUTHORIZATION

(MC/V, Debit, HSAs, etc.)

- You understand that I need to keep business procedures simple so that I may concentrate energies on helping YOU.
- Therefore, you are expected agree to Payment Authorization. Doing so simplifies payment of non-covered services.

CONTRACT & CONSENT

- You, the client or parent/guardian, voluntarily consent and authorize me to administer psychotherapy.
- You are aware psychotherapy is not an exact science.
- You acknowledge no guarantees have been made as to the result of psychotherapy.
- You understand I practice under guidelines set forth by the Kentucky and my professional association.
- You understand I make appropriate referrals if you have needs that I am unable to address.

MANDATORY DISCLOSURE

You acknowledge I am obligated by law and regulations to report any information regarding the following:

- When you disclose intentions to harm another person or yourself.
- If you state or suggest that there is abuse, abandonment or neglect of a child or vulnerable adult; or a child or vulnerable adult is in danger.
- If you report domestic violence or spouse abuse.
- If you report admitted prenatal exposure to controlled substances that are potentially harmful.
- Failure to cooperate with treatment plans ordered by court, probation, parole or Cabinet for Human Services.

MINOR CLIENTS

In certain situations I may have to see proof of guardianship, custody or court orders.

PRIVACY POLICY

You have rights regarding your Personal Health Information (PHI):

- You can be communicated with in a particular way or at a certain time / place. For example, you can ask me to only call on your cell phone.
- You have the right to look at your PHI. You have the right to one copy of your PHI.
- If you believe your PHI is incorrect or missing information, you can ask me to make changes. You must specify in writing the reasons you want me to make the changes.
- You have the right to file a complaint if you believe your privacy has been violated. You can file a complaint with me or with the Cabinet for Human Services. All complaints must be in writing.

- Your PHI will be released when a *court order* has been placed.
- Parents or guardians of *non-emancipated minors* have the right to access your PHI.
- In the *event of death*, the spouse, parents of a deceased minor client, or those with durable power of attorney have the right to access your PHI
- Third-party payers, billing services, and collection agencies are given limited information regarding services.

AUTHORIZATIONS & REFERRALS

- You must obtain authorizations & referrals required by your 3rd-pary payers in order to see me.
- HMO plans always require referral from your Primary Care Provider.
- Employee Assistance Plans (EAR) always require that I get written authorization.
- Failure of you to do so makes you responsible for all fee.

RELEASE OF INFORMATION

- You understand the Release of Information (ROI) is a legal requirement for my seeing you.
- The ROI allows me to contact others, if necessary.
- Many 3rd-party payers require that I *must* contact your primary care provider, psychiatrist, or referring practitioner – unless you opt-out.
- The ROI must be signed.

COURT / LITIGATION

- You understand in litigation my role is to *not* make recommendations for the court or to testify concerning opinions on issues involved in the litigation.
- You agree to call me as a witness in any litigation only upon prepayment.
- Probation, disability and court paperwork are your personal responsibility and is billed at $140/hour at $35 increments. Court appearances are billed at $200/hour and must include travel and wait times. Increments are hourly.

ACCEPTANCE OF AGREEMENT

- The Registration Form contains the signature lines for all required policies.
- Your signature agreeing to these policies is **mandatory** in order for me to treat you. Only Payment Authorization is optional.

QUESTIONS OR PROBLEMS

If you have questions or problems with any of these policies, just talk with me.

9/3/2021

Please Continue to Fill in the Next 5 Pages

BACKGROUND INFORMATION

This information is beneficial to providing services to you. If you don't understand any area or any area makes you uncomfortable in any way, let me know when we meet.

Client_____ **DoB**_____ Date: _____

1 Why are You Seeking Help?_____

_____

2 Reasons for Seeking Help Now_____

_____

3 Primary Care Provider + Contact Information_____

4 History of Mental Health Problems?	Yes	No	Don't Know
Hospitalized?	Yes	No	Don't Know
Outpatient Treatment	Yes	No	Don't Know
On Medications	Yes	No	Don't Know
History of Violence or Suicide Attempts	Yes	No	Don't Know
Thoughts about Suicide or Violence	Yes	No	Don't Know
Other	Yes	No	Don't Know

If **Yes** to Any, Please Tell Me More_____

_____

5 Problems in Functioning?	Yes	No	Don't Know
School	Yes	No	Don't Know
Work	Yes	No	Don't Know
Family	Yes	No	Don't Know
Peers	Yes	No	Don't Know
Social Activities	Yes	No	Don't Know
Eating	Yes	No	Don't Know
Sleeping	Yes	No	Don't Know
Day-to-Day Activities	Yes	No	Don't Know
Other	Yes	No	Don't Know

If **Yes** to Any, Please Tell Me More_____

_____

6 Current Legal, Probation, Parole Problems? Yes No Don't Know

If **Yes**, Please Tell Me More_____

7 Current Medical Problems?	Yes	No	Don't Know
On Medications	Yes	No	Don't Know
Recently Hospitalized	Yes	No	Don't Know
Under Care of Health Care Professional	Yes	No	Don't Know
Other	Yes	No	Don't Know

If **Yes** to Any, Please Tell Me More_____

_____

8 History of Medical Conditions	Yes	No	Don't Know
Drug Allergies	Yes	No	Don't Know

Tell Me More About Your Condition_____

BACKGROUND INFORMATION

9 Alcohol Use Yes No Don't Know

Last Date Consumed____/_____/___ Amount_____ What?_____

Any Increase in Tolerance Yes No Don't Know

Blackouts Yes No Don't Know

Tell Me About Your Alcohol Use_____

_____

10 Drug Use Yes No Don't Know

Last Date Consumed_____/_____/___ Amount _____ What?_____

Any Increase in Tolerance Yes No Don't Know

Tell Me About Your Drug Use_____

_____

11 Chemical Dependency Treatment Yes No Don't Know

Tell Me More_____

_____

12 Disabled Full Partial No Don't Know

Tell Me More_____

_____

↔↔↔↔↔↔↔↔↔↔↔DO NOT WRITE BELOW THIS LINE ↔↔↔↔↔↔↔↔↔↔↔↔

13 Strengths / Assets_____

_____

14 Preliminary Assessment_____

_____

15 Preliminary Dx(s) _____

16 Accepted for Treatment Yes No Further Evaluation Yes No

17 If Not Accepted, To Whom Referred To & Why: _____

_____

18 Initial Treatment Goals_____

19 Initial Prognosis_____

20 Other Relevant Information _____

Therapist Signature: _____

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AAMFT Clinical Member

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Registration

dx_____

(PLEASE PRINT)

CLIENT NAME, Last_____First_____

*If I may contact you by e-mail, please print your e-mail address*_____

Address_____ City_____

ST____ ZIP_____ **SSN**_____ **D**of**B**_____

Cell_____Home_____ Gender_____

NOT OK to leave message_____ **NOT OK** to leave message_____

Employer _____ *(SSN is required for certain 3rd-Party Payers)*

RESPONSBILE PERSON – if other than client. If client's name is NOT on insurance card or EAP authorization, you must provide *THE* subscriber's or employee's full name and date of birth and SSN.

Last Name_____First_____ **D**of**B**_____

Address_____City_____ State_____

ZIP_____ SSN_____ Relation to Client_____Gender ___

Cell_____Home_____

NOT OK to leave message_____ **NOT OK** to leave message_____

Employer_____ *(SSN is required for certain 3rd-Party Payers)*

3rd –PARY PAYER / EAP _____

ID #_____ Authorization #_____

EAPs *require* the client *and* employee SSN**. _____**

Tricare requires the military sponsor's SSN**. _____**

EMERGENCY CONTACT_____

You consent for Mike Rankin to contact this person during any emergency as defined by Mike Rankin, LMFT

Phones, Cell_____Home_____

HOW DID YOU HEAR OF MY SERVICES?_____

HAVE YOU HAD PRIOR COUNSELING? Y N If *Yes,* briefly describe what was helpful about it?

_____

AGREEMENT TO POLICIES

I have been given a copy of the **POLICIES** brochure. I understand and agree to the **Financial Agreement, Cancellation / Late / No-Show, 3rd-Party Payer Release and Assignment, Contract and Consent, Mandatory Disclosure, Minor Client(s), Privacy Policy, Authorizations & Referrals, Release of Information, Court / Litigation, Acceptance of Agreement** as well as the **Emergency Contact** provision.

_____ _____

Client or Responsible Party Signature Date

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RELEASE OF INFORMATION

All clients with 3rd-party payers MUST make a choice below and sign this form.

Client_____ DofB_____

1. I understand that most 3rd-party payers **require** Mike Rankin, LMFT, inform my primary care practitioners, psychiatrists, or care professionals that I am receiving psychotherapy -- **unless I opt-out of that requirement by marking the line immediately below.**

   ↓

   _____ *At this time*, I do not want Mike Rankin, LMFT, to contact any care professional regarding my psychotherapy.

or

2. I want Mike Rankin, LMFT, to communicate with the party named below. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This authorization shall be valid for the length of treatment with Mike Rankin, LMFT, or until canceled by me. I hereby relieve and release the below mentioned from any and all damages, claims and causes of action arising out of, or in connection with the release of this information. I agree that a photocopy of this form may be used in lieu of the original. This may include your diagnosis.

   ↓

   _____ I authorize and consent to Mike Rankin, LMFT, to release, obtain and consult by written, verbal or electronic communication with:

Doctor, Psychiatrist, Lawyer, etc. from Whom Information is to be Received or Sent:
(Use A Separate Form for Each and Every Provider)

Name _____

Address _____

_____

Phone _____ Fax _____

_____ _____

Client / Responsible Party Signature Date

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PAYMENT AUTHORIZATION

(Debit, Health Savings Account, Master Card, VISA, Discover, etc. NO AmEx)

I authorize Mike Rankin, LMFT, to charge co-pays, deductibles, co-insurance, bank and other fees that may become due under the Financial Agreement.

This authorization shall be valid for the length of treatment with Mike Rankin, LMFT, or until canceled in writing by me.

A copy of all charges will be given to me, sent to me, or placed in my chart.

The following are covered under this agreement:

Name *(print)*_____

Name *(print)*_____

CARDHOLDER Name *(print)*_____

ZIP Code _____
Where card statement is sent

Card Number **A copy of your card may be used in lieu of most of this information.**

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiration Date **3 Numbers on Back of Card**

☐☐ ☐☐ ☐☐☐

Month Year

CARDHOLDER Signature_____ **Date**_____

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